



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Submit to:

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2006 DCH CONSTRUCTION/RENOVATION PROGRAM NARRATIVE

PLEASE PRINT OR TYPE ALL INFORMATION

FAILURE TO FILL IN ALL ITEMS WILL DELAY ACCEPTANCE OF FINAL PLANS FOR REVIEW AND APPROVAL.

Date Submitted: _____

Facility Name: _____

Project Name: _____

Project Authorization:	CON Project Number/Date Issued	_____	_____
(Include copy of approval)	DET Request/Date Issued	_____	_____
	LNR/Date Issued (Amb Surg Only)	_____	_____

If a CON, DET or LNR has not been issued by the Georgia Department of Community Health please describe the project below:

Estimated Construction Cost: _____

Estimated Equipment Cost: _____

Desired Start of Construction: _____

End of Construction: _____

Owners Signature: _____
(Not the Architect) OWNER SIGNATURE

PRINT NAME

Notary statement and seal:

NOTARY SIGNATURE

PRINT NAME

CON = Certificate of Need and is issued to Hospitals, Nursing Homes and Ambulatory Surgery Centers.

DET = Determination Request, an official letter from DCH stating project does not require a CON.

LNR = Letter of Non-Reviewability and is issued to Physician Owned Single Specialty Ambulatory Surgery Centers with project costs less than the Current CON Thresholds.

DCH USE ONLY

PROJECT # _____ DATE REC'D _____